THIRD PARTY INSURANCE COORDINATION OF BENEFITS
EARLY INTERVENTION

Date: _____

Provider ID _____ Provider Name _____

Patient Name:	Patient MID	Dates of Service	Procedure Code(s)
_____	_____	_____	_____
			_____

Name of Primary Commercial Health Insurer: _____ Policy Holder name: _____ Policy Number: _____

Name of Secondary Health Insurer (if any): _____ Policy Holder name: _____ Policy Number: _____

_____ EI Benefits Exhausted for this calendar year. Total amount of benefits Paid $_____ for year ended _____

_____ Primary Commercial Insurer Does Not Cover EI Benefits:
Employer (through whom insurance is provided): _____ Explain: _____

_____ Secondary Commercial Insurer Does Not cover EI Benefits:
Employer (through whom insurance is provided): _____ Explain: _____

_____ Other (Please Explain) _____

Provider/Agency Confirmation Of Denied Services

I certify that to the best of my knowledge, I have determined that the EI services are not covered under the benefits of this commercial insurance policy as documented above.

Name: _____ **Signature**: _____ **Date:** _____